

Governor Schwarzenegger's Health Reform Proposal
Health Care Security and Cost Reduction Act
RN 07 29963 (10/9/07)

Individual Mandate

- Effective July 1, 2010, every California resident must obtain "minimum health care coverage" for self and dependents.
- Complying coverage includes:
 - Individual or group health care service plan or health insurance coverage meeting standards established by the California Secretary of Health and Human Services and promulgated in regulation by 1/1/09. Minimum benefit plan established by the Secretary must cover medical, hospital, and preventive services.
 - Public programs such as Medicare; full scope, no share of cost Medicaid; Healthy Families; Indian Health Service coverage; and certain county-sponsored low-income health coverage.
 - Federal employee health coverage and CalPERS coverage for state employees and retirees.
 - Public health plans as defined in the federal Public Health Service Act.
 - Coverage through the MRMIB-administered purchasing pool established in the bill.
 - Employer-sponsored health coverage (insured or ERISA self-funded).
 - Taft-Hartley coverage.
 - State-licensed Multiple Employer Welfare Arrangements.
 - MRMIP coverage.
 - Champus, Tricare and veterans' coverage.
 - Student health coverage and Peace Corps volunteer coverage.
- CHHS Secretary must, if funded to do so, establish methods to inform individuals of their obligation to obtain coverage as well as available public coverage. Secretary must establish methods to ensure that uninsured individuals secure minimum coverage. Individual mandate is contingent on the Secretary's implementation of these mechanisms.

State Purchasing Program

- Establishes the Health Care Security and Cost Reduction Program, administered by MRMIB.
- Offers both subsidized and unsubsidized coverage:
 - Subsidized, low-income assistance
 - Subsidized, comprehensive coverage that meets or exceeds the minimum defined by the CHHS Secretary
 - Eligibility
 - Family income greater than 100% of the federal poverty level (FPL) and less than or equal to 250% FPL

- State resident
 - Citizen, national or qualified alien
 - 19 years or older
 - Ineligible for Medi-Cal or receiving Medi-Cal benefits through the program (parent/caretakers, and 19-20 year olds)
 - If a childless adult, has no access to employer coverage
- Premiums based on income
 - >100-150% FPL: No premiums or out-of-pocket costs
 - >150-250% FPL: Premiums limited to 5% of income
- Intention to establish a mechanism to defray costs by taking advantage of enrollees' other coverage opportunities
- Unsubsidized coverage
 - Products that provide at least the minimum defined by the CHHS Secretary
 - Three levels of coverage, ranging from the minimum coverage complying with the individual mandate to the maximum, as defined by DMHC and DOI for purposes of market reforms
 - Board discretion to offer dental and vision coverage if board makes findings that this will provide a significant benefit for the health coverage marketplace, will be cost effective, and will not cause undue risk of adverse selection
 - Eligibility
 - State resident
 - Eligibility for health coverage: Individuals who are employees paying full cost of coverage through a cafeteria plan, are eligible for a state tax credit administered by MRMIB, or are employees who do not have access to employer-sponsored health insurance with some employer contribution
 - Eligibility for dental and vision coverage, if offered: Individuals who are enrolled in health coverage through the program
 - Premiums: Must reflect the cost of obtaining coverage from participating health plans and the administrative cost associated with the coverage
 - Costs partially offset by a tax credit or Section 125 benefit for those eligible
 - If tax credit implemented, MRMIB to advance participants' estimated tax credit for purpose of paying all or part of the participant's premium

Tax Credit for Purchase of Qualified Premiums

- Legislative intention to establish a refundable tax credit for individuals not eligible for publicly subsidized coverage.
- Credit would be equal to that portion of the “premium for minimum coverage” that exceeds 5% of adjusted gross income. “Premium for minimum coverage” means the average standard risk rate for minimum coverage available through the Health Care Security and Cost Reduction Program, administered by MRMIB.
- Tax credit is available only to individuals who:
 - are not eligible for coverage under an employer sponsored group health plan;
 - have adjusted gross income of 250-350% FPL; and
 - purchases coverage through MRMIB.
- MRMIB would estimate an individual’s tax credit and pay it toward the cost of coverage.

Public Program Expansions

- Expands Healthy Families to include all children (documented and undocumented) up to 300% FPL.
- Expands Medi-Cal to income-eligible children under 19, regardless of immigration status.
- Extends Medi-Cal coverage to 19 and 20 year olds, parents and caretakers up to 250% FPL and childless adults up to 100% FPL. Eliminates the Medi-Cal asset test.
- Limits coverage for children ages 19-20, parents/caretakers and childless adults to a new benchmark plan equivalent to the subsidized coverage offered through the MRMIB-administered purchasing pool.

County Participation

- Makes some subsidized coverage in the purchasing pool and coverage of childless adults under 100% FPL contingent on certain county contributions.
- Permits the Medi-Cal program to enter into at-risk contracts with counties that have coverage for low-income childless adults, under a new Local Coverage Options (LCO) program.

Medi-Cal Provider Rates

Increases Medi-Cal hospital and physician rates:

- Requires physicians to be reimbursed at no less than 80% of Medicare rates.
- Requires private and district hospitals to be reimbursed at Medicare rates and public and UC hospitals at costs up to federally allowable levels.

Insurance Market Rules

- Requires health plans and insurers to offer, accept and renew all individual private coverage products regardless of the age, health status or claims experience of applicants ("guaranteed issue and renewal"). Guaranteed issue is contingent on implementation of the CHHS Secretary's individual mandate enforcement activities.
- Establishes rating rules for individual coverage:
 - Director of Managed Health Care and Insurance Commissioner of Insurance define limits on the differential between age-based rates for persons aged 30-35 and age-based rates for those 60-64.
 - Places limits on geographic rating (similar to existing small group market rules).
 - Phases out any rating factor based on health status:
 - First three years: +/- 20% compared to standard rates
 - Second three years: +/- 10% compared to standard rates
 - After first six years: No adjustment based on health status (regulators may delay up to two years to ensure coverage availability)
 - Regulators must establish five tiers of individual coverage.
 - Generally limits individuals to moving up one tier per year, except at a qualifying event, such as loss of group coverage, marriage, divorce, birth of a child, death of the primary subscriber or loss of dependent status.
 - Medical Loss Ratio:
 - Plans to spend at least 85% of after-tax revenues on health care, calculated across all of a carrier's products
 - Administrative costs excluded from health care costs
 - Disease management, training and informational materials, telephone advice and payments to providers based on performance included in health care costs

Tax Treatment of Health Coverage

- Requires all employers to establish Section 125 accounts to allow employees to pay for health coverage with pre-tax dollars.
- Conforms state tax law to federal law, which allows a tax deduction for health savings account contributions.

Cost Containment

Includes a variety of provisions, including:

- Electronic prescriptions.
- Greater use of nurse practitioners, nurse midwives, and physician assistants.
- Programs to manage chronic conditions, including diabetes and obesity.
- Electronic personal health records in state-administered health coverage programs.
- Transparency of health care cost and quality data and information.
- Public and private "Healthy Action Incentives and Reward Program" coverage.

Financing

- States legislative intent to finance the plan with contributions from employers, individuals, federal, state and local governments and health care providers.
- Intended funding sources include:
 - Increased federal Medicaid and State Children's Health Insurance Program funds.
 - Revenue from counties based on shift from county coverage to coverage provided pursuant to the proposal.
 - 4% fee on hospital patient revenues.
 - Employer fees ranging from 0 to 4% of payroll.
 - Employer contributions to coverage of their employees in public coverage.
 - Premium payments by individuals in public programs and private coverage.
 - Revenues from licensing the State Lottery.
 - State savings related to increased coverage.

Implementation

Implementation is contingent on a finding by the Director of Finance that sufficient financial resources are available.